

Matters arising

Labial adhesions after genital herpes infection

Sir,

Waltzman and Wade¹ report a case of labial adhesions after genital herpes infection and note that only three cases have been documented previously. We have recently seen a similar case.

A 19 year old girl was referred by her general practitioner with a 4 day history of vulval soreness and dysuria. Genital examination revealed a severe vulvitis with ulceration and oedema. A presumptive diagnosis of primary genital herpes was made which was later confirmed by tissue culture. Saline bathing was advised and she was commenced on standard doses of oral acyclovir and trimethoprim. She returned the following day complaining of an inability to pass urine and was admitted to the ward. The oral acyclovir was increased to 400 mg qds. There was no clinical evidence of a sacral radiculitis and she passed urine in the bath after using topical lignocaine. She was discharged after 5 days and on review in the out patient clinic 2 days later, it was noted that although the vulvitis had settled, she had developed a 1 mm × 2 mm labial adhesion. It was suggested that she gently tease the adhesions apart whilst bathing and within 4 days normal anatomy had been restored.

In contrast to the recent report, our patient was commenced on antiviral therapy within 4 days of onset of the lesions and this clearly did not prevent the formation of adhesions. Labial adhesions may develop as a consequence of severe ulceration and/or superadded infection and although rare do occur.

We have seen one other case in the past 6 months but are unsure of the clinical outcome as the patient defaulted from follow up. To prevent this complication we recommend that women with primary genital herpes be encouraged to separate the labial folds during saline bathing. Paraffin gauze (Paratulle) may also be interposed between adjacent vulval ulcers. If adhesions develop, a trial of gradual labial separation by the patient using either plain or lignocaine gel should be considered, prior to a more radical procedure.

C A Bowman
P A De Silva
E F Monteiro

Dept of Genitourinary Medicine,
The General Infirmary At Leeds,
Great George Street,
Leeds LS1 3EX, UK

Reference

- 1 Waltzman M, Wade AAH. Labial adhesions after genital herpes infection. *Genitourin Med* 1989;65:187-8.

Labial adhesions after genital herpes infection

Sir,

Waltzman and Wade report a case of labial adhesions following acute *Herpes simplex* virus (HSV) vulvitis,¹ apparently the third reported case worldwide. In the last 10 years I have treated three such cases, all following acute HSV vulvitis. Lack of saline bathing during the acute phase was noted in all cases. I managed all three women with separation of the adhesions using gentle blunt dissection after topical then infiltrated local anaesthesia early during follow-up. Anatomic and functional results were excellent. More minor adhesions in the region of the posterior vaginal introitus are seen following episiotomy and other perinatal perineal trauma. I have also taken part in the management of a woman with transverse mid and upper vaginal adhesions associated with mucosal lichen planus of the vagina. Management consisted of initial introduction of the use of dilators followed by blunt dissection of the adhesions under general anaesthesia, followed by continuing use of dilators, with intra-vaginal administration of clotrimazole-hydrocortisone 1%. Recovery of sexual function occurred.

A further recent case was that of a woman who initially presented with an anatomically normal cervix and cervical intra-epithelial neoplasia. The lesion was treated with Semm coagulation but super-infection of the ectocervix was diagnosed at 7 days follow-up and treated with antibiotics. Six months later colposcopy revealed a double os, formed by a 5 mm wide bridge from anterior to posterior lip. The two canals merged 2.5 mm from the apparent surface. In view of recurrent cervical intraepithelial neoplasm and menorrhagia treatment was by hysterectomy. Adhesions in the female genital tract can therefore arise in a number of ways, although HSV infection is probably nowadays a common cause. It seems likely that these genito-urinary medical curiosities are underreported.

C J N Lacey

Dept of Genitourinary Medicine,
The General Infirmary,
Leeds LS1 3EX, UK

Reference

- 1 Waltzman MW, Wade AAW. Labial adhesions after genital herpes infection. *Genitourin Med* 1989;65:187-8.

Acute urethritis due to *Neisseria meningitidis*

Sir,

We read with interest the article of Dr Wilson and colleagues (*Genitourin Med* 1989;65:122-3) which described a case of acute urethritis due to *N meningitidis* group A acquired by orogenital contact. We saw a similar couple during March this year. A 25 year old heterosexual man presented with a urethral discharge and dysuria of one week duration. He admitted to fellatio with his girlfriend. A gram stained specimen showed polymorphonuclear leucocytes with intracellular gram-negative diplococci. Further urethral and throat specimens were cultured on Modified New York City (MNYC) medium. He was told that the probable diagnosis was gonococcal infection and was treated with single oral dose of 250 mg ciprofloxacin. His girlfriend was seen on the same day and specimens were taken from her throat, urethra, endocervix and rectum to culture for neisseria species on MNYC medium. She had an endocervical culture for *Chlamydia trachomatis* and microscopy and culture of the vaginal specimens. Both of them denied other sexual partners for more than a year.

The results of the microbiologic assays showed a growth of *N meningitidis* from the man's urethral specimen and the woman's throat specimen. Both isolates were not groupable and not typable and both had identical antibiotic sensitivities. Her specimens failed to grow *N gonorrhoeae*, *C trachomatis*, candida species and a wet film examination of her vaginal specimen did not show *T vaginalis*. *N meningitidis* was not isolated from her urethral and cervical specimens. Repeat testing one week later confirmed the original findings prior to treatment.

His urethritis resolved with single dose of ciprofloxacin and he remained asymptomatic on two further follow up visits. Even though we did not exclude other pathogens as the cause of his urethritis its complete resolution with a single dose of ciprofloxacin and the absence of other pathogens except *N meningitidis* in his partner's specimens favour *N meningitidis* as the aetiological agent for the urethritis.

A peak carriage rate of *N meningitidis* of over 20% in young adults was found in a large community survey.¹ In a study of 1025 female patients attending a Genitourinary Medicine clinic in London 70% of them admitted practising fellatio.² This further confirms the importance of excluding *N meningitidis* as a cause of urethritis when gram negative intracellular diplococci are found on microscopy and *Neisseria* species